No. 6873.

IN THE

United States
Circuit Court of Appeals,

FOR THE NINTH CIRCUIT.

James McCulloch, Jr.,
Appellant,

vs.

The Penn Mutual Life Insurance Company of Philadelphia, a corporation,
Appellee.

APPELLEE'S ANSWERING BRIEF.

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TABLE OF CASES AND AUTHORITIES CITED.

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The purpose of this suit has been correctly stated by the appellant (Appellant's Opening Brief, p. 1). The dates of execution and delivery of the three policies involved, together with the principal sum and the premium provided for in each, have also been sufficiently set forth. We will hereafter analyze the transactions and circumstances by and under which the premiums were paid. A careful survey of the evidence will show that all three of the policies lapsed in 1926 by reason of non-payment of premiums. Whether or not these policies continued in effect by reason of the operation of the disability provisions contained in each will receive careful consideration. In this connection we will go into the evidence in

considerable detail to determine as approximately what date the insured became totally and permanently disabled. It is the plaintiff's position that he became disabled July 10, 1926, when he became ill with pleurisy with effusions, possibly showing some traces of a tubercular condition. After considering the testimony offered in behalf of both the plaintiff and the defendant and taking into consideration the appearance and demeanor of each witness placed on the stand, the trial judge expressly found that plaintiff had not been totally and permanently disabled prior to April 10, 1927 (Tr. p. 1-4), at which date plaintiff concedes no rights under the policy could arise. (App. Op. Br. 14.) If there is any substantial evidence to support this finding concededly plaintiff's appeal fails. If any of the policies lapsed by reason of non-payment of premium or for any other cause before plaintiff became permanently disabled, it is also conceded that plaintiff cannot recover under that policy. It is our firm belief that, taking this view of the case alone, the decision of the trial judge should be affirmed. However, regardless of whether or not this Honorable Court agrees with the trial court on the above proposition, the plaintiff cannot recover under the policies involved in this suit. Each of the policies expressly provided that waiver of premium and disability benefits would not become effective until after submission of proofs of total and permanent disability, and that on the submission of such proofs the defendant would waive the payment of premiums *subsequently* falling due (not premiums falling due before submission of such proofs). The trial court properly found a further reason for rendering judgment against the plaintiff. The plaintiff's delay of over three years in bringing this action was unreasonable

and inexcusable and so worked to the disadvantage of defendant as to establish a complete defense of laches independent of the mere length of time. In order to avoid confusion and to present the facts and law involved as clearly as possible, we shall divide our discussion into the following groups:

1. Each of the three policies sued upon lapsed in 1926 by reason of nonpayment of premium.

2. The evidence clearly shows that the plaintiff did not become totally and permanently disabled while the policies were in force.

3. Submission of proof of total and permanent disability was a condition precedent to the waiver of premiums and payment of disability benefits.

4. Plaintiff's cause of action is barred by plaintiff's laches.

I.

Each of the Three Policies Sued Upon Lapsed in 1926 By Reason of Non-payment of Premium.

The appellant has evolved an ingenious and intricate mathematical formula which it is claimed conclusively proves that the premiums on all three of the policies were paid up to March 18, 1927. This formula, while extremely interesting from an academic viewpoint, utterly disregards the evidence produced at the trial on behalf of both plaintiff and defendant. The trial court expressly found that policy No. 1196774, by its terms, lapsed for nonpayment of premiums on November 28, 1926 [Findings 12, 13 and 14, Tr. 147, 148]; that policy No. 1196773 lapsed on the same date for the same reason [Fdg. 23, Tr. 152] and that policy No. 1191014 also lapsed for the

same reason [Fdgs. 5 and 8, Tr. 143, 145]. If there is any substantial evidence to support these findings, this Honorable Court should not disturb them. (App. Op. Br. 14.) The evidence on this point was not even conflicting; it all supported defendant's contentions. There was no evidence offered or presented to show that the premium on either of the policies was paid beyond the dates found by the trial court. It is true that plaintiff gave Mr. Carrell a note for $339.39, but the evidence clearly shows that only $276.29 was for term insurance, which went to pay back premiums. The balance was not meant to cover insurance under all or any of the policies. The testimony and evidence conclusively shows that this was a personal note given to Mr. Carrell and that it included certain other sums Carrell had paid out of his own pocket to take up bad checks given by the plaintiff to others. These advancements were an act of friendship made to prevent plaintiff's being criminally prosecuted and had no connection with the policy issued by defendant on plaintiff's life. [Tr. 225-231.] On cross-examination Charles L. Randolph testified [Tr. 228]:

> "Part of the difference between the two amounts $233.40 and $339.39 was personal between Mr. McCulloch and Mr. Carrell. I don't know what that represents. (Letter, Plaintiff's Exhibit 14 for identification.) That is part of the record of my files. The total amount of the term charge for which Mr. McCulloch gave his note to Mr. Carrell personally was $276.29, and there was an item of $64.79 which I understood represented a check which he took up for Mr. McCulloch in order to prevent him from being criminally prosecuted and he included this in the note to Mr. Carrell."

and in a letter written by Mr. Randolph to the defendant's home office, which was introduced into evidence by plaintiff as Exhibit No. 14, appears the following information [Tr. 229]:

> "We were billed Feb. 21, 1927 for term insurance as follows:
>
> Policy No. 1196773, (which is C) $48.00;
>
> Policy No. 1196774, (which is B) $185.40;
>
> Policy No. 1191014, (which is A, in typewriting) $41.20 (and then the figures in pencil), $42.98.
>
> Total (in typewriting) $274.60 (and in pencil), $276.29.
>
> This was paid by our agent, Don C. Carrell, and he has McCulloch's note for this amount, plus $64.79, representing a check which McCulloch issued that was not good and which Mr. Carrell paid to save criminal action being brought against him. Total amount of the note which Mr. Carrell holds is $339.39. McCulloch has not at any time paid one cent on it. The note, of course, is individual, and the Penn Mutual's name is not mentioned."

Plaintiff introduced this letter and should be bound by it, from this it is apparent that the balance of the $339.39 note represents sums paid by Mr. Carrell to prevent criminal prosecution against the plaintiff. It is, of course, obvious that no portion of that note was intended to be applied to payment of premiums on the policies in question to extend them beyond the date of their surrenders. The note was given on April 19, 1927 [Tr. 169, 178], sometime after the policies had expired and been surrendered and *after plaintiff's application for reinstatement had been denied*. Clearly the parties could not have intended this transaction as a reinstatement of the policies,

even assuming that there had been a mistake in the amount for which the note was made out. Such a mistake could not revive the expired policies. There would have had to have been a formal reinstatement of the policies with a new medical examination and the attendant formalities. It is also well to note that any further evidence on behalf of the defendant would have had to come from Mr. Carrell who at the date of the trial was on his death bed. This is just one example of how defendant was prejudiced by plaintiff's delay of over three years in informing the defendant of his claim.

We submit that Mr. Randolph's testimony, together with the letter introduced by plaintiff as Exhibit 8, constituted sufficient evidence to justify the trial court's conclusion on this point, particularly in view of the total absence of any evidence to the contrary.

II.

The Evidence Clearly Shows That the Plaintiff Did Not Become Totally and Permanently Disabled While the Policies Were in Force.

A. There Was no Coercion, Intimidation, Threats or Fraud Used to Procure the Surrender of the Policies.

From a reading of plaintiff's bill, together with appellant's opening brief (p. 7), one would be thoroughly convinced that the utmost fraud and sharp practice was indulged in by the defendant appellee, through its agents and through the assistance of the district attorney's office, to procure the surrender of these policies. However, the testimony clearly shows that this was not the fact and

the trial court expressly so found. In the memorandum opinion the lower court expressly stated [Tr. 134-135]:

> "The complaint is very much enlarged by charges against the defendant and its agents of duress, intimidation, and imposition by them, and other harrassments of plaintiff when sick; expressed in many forms and which, it is alleged, affected his conduct prejudicial to his rights. We find the proof utterly lacking in these respects; that there is no justification whatever in the record for any of these charges; and that, on the contrary, it is evident that the company, through its agents, was extraordinarily lenient in carrying the policies and in overlooking the defendant's failure to either pay, when due, the premiums or the obligations he had entered into to meet them; that such consideration by defendant and its agents rebuts, effectively, any reasonable inference that defendant sought to escape the burdens of the policy contracts.
>
> *We find specifically that there was no overreaching of the plaintiff in any way when, in December, 1926, and in March, 1927, he surrendered his policies and gave the several surrender notes in evidence;* and that each of such surrenders effectively and permanently terminated any responsibility to plaintiff from defendant, growing out of the several contracts theretofore subsisting." (Italics ours.)

and on page 136:

> "The testimony for the defense by Cornell leaves no foundation for a conclusion that the March 18 transaction was the result of duress."

The testimony of Mr. John D. Cornell of the district attorney's office, an impartial and disinterested witness, shows, beyond any reasonable doubt, that there was not

the slightest over-reaching of the plaintiff. His testimony was short and conclusive. He wrote to the plaintiff in his official capacity in 1927, when he was county detective. [Tr. 223.] He wrote two letters, one on March 7, 1927 [Defendant's Exhibit K, Tr. 223] and the other dated March 16, 1927 [Defendant's Exhibit L, Tr. 224]. Exhibit K reads:

"March 7th, 1927.

"Mr. James McCulloch, Jr., care of McCulloch Hospital, 914 Beech St., San Diego, California.

Dear Sir:

Please call at this office at your earliest convenience and ask for the undersigned.

Yours truly,

STEPHEN CORNELL,
District Attorney.
By Chief Investigator."

and Exhibit L reads:

"Mr. James McCulloch, Jr.,
Care of McCulloch Hospital
914 Beech St., San Diego, California.

Dear Sir:

Under the date of March 7th, I wrote you asking that you call at this office.

We have had no response from you and unless a response is made to this office personally a warrant will be issued for your arrest. This communication is final, and trust that you will take advantage of the opportunity that is given you.

Yours very truly,

STEPHEN CORNELL,
District Attorney.
By JOHN D. CORNELL,
Investigator."

These two letters were written on account of some checks, but the checks involved were those given to the nurses at the hospital by plaintiff when he was in charge of it. These checks had been turned over to Cornell of the district attorney's office by the nurses. [Tr. 224.] Cornell never had the $300.00 check in his possession in his official capacity. [Tr. 224.] Can this testimony be construed to support the statement of appellant

> "A postdated check for $300.00 and an additional note was given by him to the agent [Tr. 167], but he was unable to deposit available funds to meet the check. The check was placed in the hands of the district attorney and prosecution was threatened. As a final result Mr. McCulloch surrendered the policies to the agent for the defendant and a note for $339.39, dated April 19, 1927, payable to defendant's agent, was executed. [Tr. 169.]" (App. Op. Br. 7-8.)

Obviously not. It is also well to remember that these transactions between Cornell and the plaintiff took place in March, 1927, *after the policies had expired* and after two of the policies had been surrendered on December 30, 1926. Hence the alleged duress and overreaching of the plaintiff could not possibly have had any effect on the expiration of the policies. We feel, and the trial court felt, that contrary to the plaintiff's contentions, the defendant insurance company was extremely lenient with the plaintiff in carrying the policies and overlooking the plaintiff's failure to either pay when due the premiums or the obligations he had entered into to meet them, and that this leniency and consideration completely rebuts any inference that defendant is seeking to escape any just obligations to the plaintiff.

B. When did Mr. McCulloch, the Plaintiff, Become Permanently and Totally Disabled?

We concede that the plaintiff was sick in July, 1926, but the evidence plainly shows that he was not permanently and totally disabled from and after that date. Not only does the evidence justify the trial court's finding on that point, it compels it. Mr. McCulloch had received his policies and knew of the disability benefits provided for in each. Whether or not he knew of them as a fact, he is bound by knowledge of the contents of each as a matter of law.

Wyss-Thalman v. Maryland Casualty Co., 193 Fed. 55;

U. S. Casualty Co. v. Charleston etc. Co., 183 Fed. 238;

Madison v. Maryland Casualty Co., 168 Cal. 204;

Kahn v. Royal Indemnity Co., 39 Cal. App. 180.

Had he been permanently and totally disabled, he would have immediately put in his claim. The record shows that he was badly in need of money at that time. Why did he fail to claim the usually welcome disability benefits? The only answer is that he was not totally and permanently disabled. He still retained the policies in his possession until their surrender in December, 1926, and March, 1927. Yet during all this time he made no move to collect benefits in spite of his dire need of financial aid. The true date of his total and permanent disability is better shown by claims for disability presented by this same plaintiff to other insurance companies under policies similar to those issued by this defendant. During this same period of time plaintiff was carrying insurance with two other insur-

ance companies and to which he subsequently made application for disability benefits. The insurance he carried with these two other companies was in force before he bought insurance from the defendant. When he made application to them for disability benefits he did not claim he was disabled in 1926, but, on the contrary, in his application to the Metropolitan Life Insurance Company [Defendant's Exhibit E, Tr. 195], he stated that the date of injury or the beginning of the illness causing his disability was about April 10, 1927. [Tr. 196.] This was sworn to by Mr. McCulloch, the plaintiff, on June 13, 1927, and plaintiff's own doctor examined him and signed an affidavit stating that continuous and total disability commenced April 6, 1927. [Tr. 198.] This doctor's statement is Defendant's Exhibit F. [Tr. 197.] This medical testimony was produced at Mr. McCulloch's own expense and from his attending physician. Subsequently he made another application to the same company for total and permanent disability benefits which also contained a sworn statement that the beginning of the illness causing his present condition was April 20, 1927, also that he had quit work April 3, 1927, due to business reasons. [Tr. 200.] In plaintiff's notice and proof of disability claim to the Acacia Mutual Life Association [Tr. 209, 210], the truth of which was sworn to by himself, the plaintiff stated that he became totally disabled April 10, 1927. He testified that he filled in the blank himself. [Tr. 211.] The sworn statement of the attending physician, Doctor Pache, that accompanied the application contained the question and answer [Tr. 207]:

> "10. At what date did total disability begin? (1) Since July 6, 1927, from personal observation at date first seen, but according to history of the case, since April 9, 1927, when he was confined to his bed."

In addition to all of this convincing evidence regarding the date of commencement of plaintiff's disability, we have plaintiff's own sworn statement made and sent to defendant, expressly intended to induce defendant's reliance thereon in allowing a reinstatement of the policies. This sworn statement is contained in plaintiff's application for reinstatement dated February 14, 1921. [Tr. 191 to 194, incl.] In said application it is stated:

> "3. Are you in good health? Yes." [Tr. 192.]

and further [Tr. 193]:

> "*I hereby certify that my health is not impaired;* that I have not consulted a physician during the past three years, except as stated above, *and I hereby declare that my answers to the foregoing questions are full, complete and true,* and are made for the purpose of inducing the Penn Mutual Life Insurance Company to comply with the request as stated in answer to Question No. 1 hereof, and it is understood and agreed that no liability on the part of the Penn Mutual Life Insurance Company shall arise under this health certificate until it has been approved at the home office of the company in the city of Philadelphia, Pennsylvania, and the premium has been paid, during my lifetime and good health. Dated at San Diego, this 14th day of Feb. 1927." (Italics ours.)

Plaintiff has sought to minimize the importance and significance of this last document by saying (App. Op. Br. 27):

> "There is not a syllable of testimony to indicate that McCulloch actually knew that he was affected with tuberculosis. His statement to Dr. Anderton, the insurance examiner, therefore, does no more than corroborate plaintiff's contention that he was then ignorant of the fact that the disability from which he was suffering was total and permanent. Such statement or admission proves nothing further."

We submit that no sane man operating a hospital and being around invalids all of the time could be totally disabled and not know it. It was not a question of knowing whether or not he was suffering from any particular illness. It was a question of his knowing whether or not he was totally and permanently disabled by bodily injury or disease from engaging in any occupation whatever for remuneration or profit [Tr. 48, 106]. Accompanying the application for reinstatement was a certificate of health from the medical examiner, Dr. Anderton [Tr. 194], showing that he had knowledge of the history of lobar pneumonia. This certificate shows that at the time of that examination for reinstatement, February 14, 1927, plaintiff's lungs were free from abnormalities and his heart and blood pressure were normal. This examination was made at the expense of the applicant [*i. e.* plaintiff, Tr. 220]. Doctor Herbert S. Anderton was called as a witness and his testimony alone justifies the trial court's finding that plaintiff was not totally and permanently disabled while the policies were in force. This witness is a man who specialized in pulmonary tuberculosis at the California Sanitarium at Del Mar, California. [Tr. 218.] He was on the tubercular consulting board in France for a year, where he did nothing but chest work. He knew

plaintiff from the time he took over the hospital, which was for a good many years. [Tr. 218.] His impression of Mr. McCulloch's condition at the time he examined him upon Mr. McCulloch's own application for reinstatement of his insurance was that Mr. McCulloch had completely recovered from the lobar pneumonia which he had had in July, 1926. [Tr. 218.] *"His condition was perfectly healthy."* After Mr. McCulloch was up and around and had recovered from his pneumonia and had returned from the hospital, Doctor Anderton saw him nearly every day performing his usual duties, and at the time when Doctor Anderton examined him he was still performing his usual duties and maintaining that he was in perfect health. [Tr. 219.] He examined the X-ray plates offered in evidence by the plaintiff and found that they showed fluid at the base of the lung, some fibroid deposit at the apices with calcareous deposits, which is something found in many supposedly normal individuals. [Tr. 219.] His diagnosis from the X-ray plates was an unresolved pneumonia with fluid. This doctor had received from Mr. McCulloch a definite history of the lobar pneumonia which the plaintiff had suffered in July, 1926, and because of those facts made a careful examination of his chest. His findings by reason of that examination were negative: otherwise he would not have recommended a reinstatement of the policy. At the request of the court, the doctor answered numerous questions concerning tuberculosis relative to his examination of the X-ray plates and stated that he did not see any signs of an active tuberculosis [Tr. 221], and, after having looked at the X-ray plates and having read Doctor Kinney's report (the man who took the X-rays), stated that there was not an active tuber-

culosis existing. [Tr. 222.] In fact, going through all of the doctor's testimony, the condition which he found when he examined the man for reinstatement was that the man was well and normal. In going over the clinical reports of the year 1926, he found nothing to indicate tuberculosis any more than would indicate pneumonia with effusions.

In seeking to avoid the effect of this damaging evidence, counsel for plaintiff argue (App. Op. Br. 26):

> "Dr. Anderton's testimony, however, failed utterly to withstand the test of cross-examination. He testified that although he saw no indication of active tuberculosis, he had no X-ray findings or other proper examination to determine this question. [Tr. 219.] He also testified that the examination given the plaintiff at that time was an ordinary life insurance examination, no other examination being made. [Tr. 220.]"

This does not truly state the situation. Doctor Anderton's testimony, appearing on page 220 of the transcript, states:

> "I examined him for life insurance previous to that time, but not as to his physical condition from the standpoint of a patient. At the time he took out the Penn Mutual policies. That was in the fall of 1925. I gave him the ordinary life insurance examination. Aside from those, I made no other examination. Because of the history given me I made a careful examination of Mr. McCulloch's chest when he gave me the definite history of lobar pneumonia that he had in July, 1926. My findings of that examination were negative, otherwise, I would not have recommended a reinstatement of his policies."

In view of this type of examination having been made, was it necessary for a doctor specializing in pulmonary tuberculosis to have X-rays to be able to tell whether or not the applicant was totally and permanently disabled from that disease? If we adopt the plaintiff's definition of "total and permanent disability," are any of us not permanently and totally disabled? If it takes an experienced specialist with X-rays to tell whether or not total and permanent disability exists, we may all be running around permanently and totally disabled and utterly unconscious of it. Even the plaintiff himself thought that he was at that time in good health [Tr. 191] until years later, when his righteous indignation was aroused by having to pay a just debt, the note executed to Don Carrell in March, 1929 [Tr. 170], then he started to figure out a method of retaliation and decided to press this alleged claim.

We submit that the foregoing evidence not only justified the trial's court's finding that plaintiff was not permanently disabled while the policies were in force, but that it compels that conclusion.

To briefly summarize the evidence supporting the finding attacked, we find:

(1) Plaintiff's sworn statements in his written applications to both the Metropolitan Life Insurance Company and the Acacia Mutual Life Association fixing the date of commencement of his total and permanent disability as of sometime in April, 1927. It is obvious that the sole purpose of fixing his disability as against our client as commencing in 1926 was to obtain the benefit of the policies involved in this action. He could not fix the disability in regard to these policies as of the date when he fixed

it regarding the Metropolitan and Acacia policies and hope to recover from the defendant in this case.

(2) His written application for reinstatement dated February 19, 1927 (Defendant's Exhibit D). In this document he stated under oath that he had fully recovered from his previous illness, and that he was in good health at that time.

(3) The report of Doctor Anderton, the tubercular specialist who examined him on his application for reinstatement (Defendant's Exhibit H), and certified that he was in good health.

(4) The testimony given by Doctor Anderton at the trial relative to the examination of X-ray plates made in court which, in his opinion, did not show active tuberculosis when these plates were taken in July, 1926.

Counsel for plaintiff to support their claim that there was no evidence to show that plaintiff was not totally and permanently disabled, have cited numerous state court decisions showing what jury and trial court findings as to total disability will not be reversed. We are certain that the evidence just discussed shows that plaintiff was not totally and permanently disabled irrespective of what definition of total and permanent disability is adopted. The trial court found that the plaintiff was not totally and permanently disabled. If there is any substantial evidence to support his findings, that is all there is to it. Unquestionably every case of alleged total and permanent disability must rest upon its own facts. It is true, as appellant contends, that a man may be permanently and totally disabled although he does some work and attends

to some business, which in all probability his physician does not recommend. However, we submit that in the case before Your Honors there was sufficient evidence to support the finding that plaintiff had completely recovered from his illness of the early part of 1926 and was in good health at the end of that year. None of the cases cited by appellant hold or imply that a man in good health is totally and permanently disabled. A further citation of cases on this point is unnecessary. However, we might in this connection refer to the case of *Prudential Insurance Company of America v. Wolfe,* 52 Fed. (2d) 537 (C. C. A. 8th), where the court lays down the rule to be followed where an insurance policy defines total and permanent disability in terms substantially the same as those used in the policies before Your Honors. In that case the insured tested out several different jobs before finally quitting altogether. The court stated (541):

> "There is no ambiguity as to the measure provided to determine the disability or incapacity insured against. That measure is inability wholly, continuously, and permanently to perform any work for any kind of compensation of financial value. There is therefore no ground for construction. Commonwealth Casualty Co. v. Aichner (C. C. A.) 18 F. (2d) 879."

and held that evidence that insured engaged in various forms of employment, as a matter of law, prevented recovery under a policy measuring disability by total inability to perform any work for compensation. In the

case before Your Honors there was evidence which, if believed, would show plaintiff's ability to engage in some occupation (in fact in any occupation) for remuneration or profit at the time the policies were surrendered.

The case of *Pilot Life Ins. Co. v. Owen*, 31 Fed. (2d) 862, at page 864 (C. C. A. 4th), involved evidence practically identical to that before Your Honors. There the court stated:

> "Nevertheless, plaintiff claims that the evidence on the question of disability is entirely ample to show that the insured was not only disabled on December 12 and October 1, 1926, but even before July 1, 1926, when the last regular premium became due; in fact even as far back as the early spring of that year. But we do not find this to be borne out by the testimony. The insured was in poor health for some months previous to his death, but as late as December 14, 1926, that is, within a month of his death, he was actively conducting his business and continued to supervise the prosecution of work under various building contracts he had made, and which sometimes required him to travel to nearby towns. Therefore we are forced to conclude that no such disability existed as would have entitled the insured to the benefit of this particular provision of the policy. A partial, noncontinuous disability was not sufficient. One is not deemed totally disabled unless he is no longer able to do his accustomed task and such work as he has been trained to do, and upon which he must depend for a living. Metropolitan Life Insurance Co. v. Bovello, 56 App. D. C. 275, 12 F. (2d) 810, 51 A. L. R. 1040."

III.

Submission of Proof of Total and Permanent Disability Was a Condition Precedent to the Waiver of Premiums and Payment of Disability Benefits.

Let us assume (but not concede) for the consideration of this point that plaintiff was actually totally and permanently disabled during the period covered by the insurance policies in question. There can still be no recovery by the plaintiff because no proofs of disability were submitted while the policies were in force. All three of the policies involved in this case made the submission of proofs of total and permanent disability before lapse for nonpayment of premium a condition precedent to waiver of premium and payment of disability benefits. In this connection it may be well to note that policy C provided for waiver of premiums but no monthly payments in cash. Section 4 of polices A and B provides, in the first paragraph [Tr. 56, 85]:

> "Said income shall start upon the date of receipt by the Company at its Home Office during the insured's lifetime of due proof of total and permanent disability and continue thereafter for the period of the said total disability;

and in the second paragraph [Tr. 56, 85]:

> "*The Company will waive the payment of any premium falling due after receipt of due proof of total and permanent disability* and during the continuance of the said total disability of the insured." (Italics ours.)

and in the sixth paragraph [Tr. 57, 86]:

> "Immediately upon receipt of due proof of such total and permanent disability, the benefits shall become effective. * * *"

and in the ninth paragraph [Tr. 58, 87]:

> "This provision for Total and Permanent Disability Benefits shall automatically terminate:
>
> (1) Upon default in the payment of any premium;
>
> (2) If this Policy be surrendered for its cash value * * *."

In section 4 of policy C it is provided, in the first paragraph [Tr. 114]:

> "If the insured shall become totally and permanently disabled before the policy anniversary on which the age of the insured at nearest birthday is sixty years, the Company *will waive the payment of any premium falling due after receipt by the Company at its Home Office during the insured's lifetime of due proof of total and permanent disability.* * * *" (Italics ours.)

and in the fifth paragraph [Tr. 115]:

> "Immediately upon receipt of due proof of such total and permanent disability, the benefits shall become effective, subject to the conditions herein provided."

and in the eighth paragraph [Tr. 116]:

> "This provision for Total and Permanent Disability Benefits shall automatically terminate:
>
> (1) Upon default in the payment of any premium:
>
> (2) If this Policy be surrendered for its cash value * * *."

From these provisions it is clear that under no circumstances would plaintiff have been entitled to any disability benefits under any of the policies until he had filed proof of his total permanent disability at the home office of the

company, and expressly, by the terms of the policies themselves, the benefits were to begin only upon receipt of due proof of total and permanent disability. These provisions for disability are not self-executing. The plaintiff first asked to submit proofs of his disability in March, 1929. This was two years after the surrender of policy A and over twenty-seven months after the date on which policies B and C had lapsed for non-payment of premiums. Therefore, all benefits had ceased in accordance with the terms of the policies providing for automatic termination of disability benefits upon default in payment of any premium or upon the surrender of the policy. It is a well-settled rule of law that prompt payment of premiums in insurance policies is essential and provisions for such payment are a part of the contract and are conscionable, valid and enforceable, and without it the insurance business could not be carried on.

Thompson v. Knickerbocker Life Insurance Co., 104 U. S. 252, 26 L. Ed. 765;

Klein v. New York Life Insurance Co., 104 U. S. 88, 26 L. Ed. 662;

As was stated by the 5th Circuit Court, the parties are entitled to make their own contract, and the business of life insurance companies is conducted on the theory that premiums will be promptly paid at the time when they are due, and if it were otherwise it would cause untold confusion.

McCampbell v. New York Life Insurance Co., 288 Fed. 465 (5th Cir.), *certiorari* denied, 262 U. S. 729;

Sellers v. Continental Life Insurance Co., 30 Fed. (2d) 42 (4th Cir.);

and in *Long v. Monarch Accident Insurance Co.*, 30 Fed (2d) 929 (4th Cir.), the court stated:

> "We start with the general principle that in the absence of special agreement failure to pay an insurance premium when due *ipso facto* forfeits the policy."

In *New York Life Insurance Co. v. Statham*, 93 U. S. 24, 23 L. Ed. 789, our Supreme Court stated:

> "It must be conceded that promptness of payment is essential in the business of life insurance. All the calculations of the insurance company are based on the hypothesis of prompt payments. They not only calculate on the receipt of the premiums when due but on compounding interest upon them. It is on this basis that they are enabled to offer assurance at the favorable rates they do. Forfeiture for non-payment is a necessary means of protecting themselves from embarrassment. Unless it was enforceable the business would be thrown into utter confusion."

A further citation of authorities on this point seems useless. It has been held by the United States Supreme Court and by numerous state courts that provisions such as those involved here do not save the policy from lapse by reason of non-payment of a premium at a time when a disability existed, where proof thereof had not been furnished by the insured. The case of *Bergholm v. Peoria Life Insurance Company*, 284 U. S. 489, 76 L. Ed. 306, plainly and emphatically lays down the rules of law that are applicable to the case before Your Honors. The appellant has sought to distinguish this case on many grounds, all of which are more illusory than real. Appellant states (App. Op. Br. 46):

> "It is entirely possible that the respondent may seek some comfort from this decision."

We do not consider it a question of comfort. It is a question of *stare decisis.* In that case the policy provided (307):

> *"Upon receipt by the Company of satisfactory proof that the Insured is totally and permanently disabled as hereinafter defined the Company will*
>
> "1. *Pay for the Insured all premiums becoming due hereon after the receipt of such proof and during the continuance of the total and permanent disability of the Insured* * * *." (Italics ours.)

We submit that the only possible distinction between this provision and those before Your Honors is that that provision used the word "pay" instead of "waive," the practical result being the same. The Supreme Court, in discussing the *Marshall* case, stated (308):

> *"In that view, the obligation to furnish proof was no part of the condition precedent to the waiver; but such proof might be furnished within a reasonable time thereafter. Here the obligation of the company does not rest upon the existence of the disability; but it is the receipt by the company of proof of the disability which is definitely made a condition precedent to an assumption by it of payment of the premiums becoming due after the receipt of such proof. The provision to that effect is wholly free from the ambiguity which the court thought existed in the Marshall policy."* (Italics ours.)

Note the language "the ambiguity which the court thought existed in the Marshall policy." In the case before Your Honors no court could have "thought" any ambiguity existed; nothing could be plainer than the language [Tr. 56]:

"Waiver of Premium. The Company will waive the payment of any premium falling due after receipt of due proof of total and permanent disability and during the continuance of the said total disability of the insured."

The court further stated the well-settled rule (308):

"It is true that where the terms of a policy are of doubtful meaning, that construction most favorable to the insured will be adopted. Mutual L. Ins. Co. v. Hurni Packing Co., 263 U. S. 167, 174, 68 L. Ed. 235, 238, 31 A. L. R. 102, 44 S. Ct. 90] Stipcich v. Metropolitan L. Ins. Co., 277 U. S. 311, 322, 72 L. Ed. 895, 900, 48 S. Ct. 512. This canon of construction is both reasonable and just, since the words of the policy are chosen by the insurance company; but *it furnishes no warrant for avoiding hard consequences by importing into a contract an ambiguity which otherwise would not exist, or, under the guise of construction, by forcing from plain words unusual and unnatural meanings.*" (Italics ours.)

Appellant makes the extremely interesting observation regarding the *Bergholm* case (App. Op. Br p. 46):

"It is to be noted that in the Bergholm case no equitable excuse was offered for failure to give the notice required by the terms of the policy."

Appellant, however, unwarrantedly assumes that they have offered a valid, equitable excuse for failure to give the notice required. Even had they done so, the Supreme Court in the *Bergholm* case covered and answered that argument, stating on page 308:

"As long ago pointed out by this court, the condition in a policy of life insurance that the policy shall

> cease if the stipulated premium shall not be paid on or before the day fixed is of the very essence and substance of the contract, *against which even a court of equity cannot grant relief.* Klein v. New York L. Ins. Co., 104 U. S. 88, 91, 26 L. Ed. 662, 663; New York L. Ins. Co. v. Statham, 93 U. S. 24, 30, 31, 23 L. Ed. 789, 791, 19 Am. Rep. 512; Pilot L. Ins. Co. v. Owen (C. C. A. 4th) 31 F. (2d) 862, 866. And to discharge the insured from the legal consequences of a failure to comply with an explicitly stipulated requirement of the policy, constituting a condition precedent to the granting of such relief by the insurer, would be to vary the plain terms of a contract in utter disregard of long settled principles." (Italics ours.)

In particular note "against which even a court of equity cannot grant relief." Considering the case as a whole and analyzing each portion, we find that it still remains an unsurmountable obstacle in the path of appellant's hope for recovery. It is a square authority for the position taken by the trial court in the instant case and for respondent's case here before Your Honors. Numerous state courts have adopted this same rule in construing similar provisions in insurance policies.

The Circuit Court for the 4th Circuit in *Pilot Life Insurance Co. v. Owen,* 31 Fed. (2d) 862, was dealing with a very similar case. That case involved a policy containing very similar provisions to those before Your Honors. No proofs of disability were ever furnished the company, nor was any claim presented until after the death of the insured. The plaintiff in that case claimed that the insured was disabled before the last regular

premium became due. While the court stated that the evidence did not so show, it went further and held that for the disability benefit to be operative, there must be not only satisfactory proof given to the company of total continuous disability of the insured, but that also the insured must submit written request that the company waive payment of premiums as they become due, meaning not those in default but those subsequently to become due. The lower court gave judgment against the life insurance company, which was reversed by the Circuit Court.

In *Courson v. New York Life Insurance Co.*, 295 Pa. 519, 145 Atl. 530, the policy provided for waiver of payment of premiums "hereafter becoming due" if the insured "shall furnish proof to the company that he has become totally and permanently disabled by bodily injuries or a disease." After paying one annual premium the insured became mentally deranged and hence disabled. He made no claim at the time and for seven years thereafter paid all premiums falling due. He died and his administratrix brought suit for recovery of the seven annual premiums paid during the insanity of the insured. The court held that the administratrix could not recover, stating:

> "We do not regard the giving of notice of disability as a condition subsequent but as a condition precedent. It is so by the very terms of the policy. The company was to only waive the premiums and endorse the waiver on the policy *if the policyholder had furnished proof satisfactory to the company of his disability*. It was the judge of the proofs. The requirement of notice of disability before the company acted was a salutary one. It enabled the com-

pany to investigate before waiving payment of the premiums and guarded it against malingerers and frauds." (Italics ours.)

It is to be noted that in the policies before this court the provisions setting forth that disability benefits were to begin only after receipt of due proof of disability are much clearer than those in the Pennsylvania case.

In *Illinois Bankers Life Association v. Byassee*, 275 S. W. 519 (Ark.), the life insurance policy lapsed nearly eight months before the death of the insured, and the court held that the insured was bound to ascertain whether or not she was permanently disabled within the meaning of the policy and give notice within the time stipulated in the policy (before lapse for non-payment of premiums) in order to recover on such a claim.

New England Mutual Life Insurance Co. v. Reynolds, 116 So. 151 (Ala. 1928), is another square authority for the holding of the trial court. In this case the insured became disabled by insanity during the period covered by the policy. The policy lapsed for non-payment of premiums. Two years later the beneficiary brought suit for the proceeds of the policy, claiming that since the insured in fact became disabled while the policy was in force, the company was bound to waive all premiums thereafter falling due, even though no proofs of total disability had been submitted by the insured or by anyone on his behalf. The Alabama court held the defendant not liable and sustained the principle that receipt of due proof of disability was a condition precedent to the liability of the company, stating:

"We are of the opinion that furnishing proof of disability to the insurance company is made a condition precedent to the waiver of premium payments under the supplemental agreement set out in the special plea above. This agreement declares: 'If the insured shall furnish due proof to the company at its home office in the city of Boston that he has become totally disabled by bodily injury or disease the company will waive payment of each preium as it thereafter becomes due during the continuance of disability.' Intervening clauses name the conditions under which such benefits are allowed and define the character of disability. They must all concur, to make the waiver effective, that the furnishing of proof is the specific condition upon which the company 'will' waive each premium 'thereafter' to become due. 'Thereafter' clearly refers to the date of furnishing proof. The clause is in no way ambiguous or devoid of meaning.

"The entire structure of the agreement negatives the idea of a self-operating waiver in the event of total disability which embodies a contractual obligation of the company to waive premiums when 'due proof is furnished.' Manifest reasons appear for thus limiting the agreement. The premium named in the policy of life insurance is the consideration for the contract. Its prompt payment is the life of the business. By the contract the renewal premium carries protection to a fixed date. Unless renewed by another stipulated premium it lapses and the rights of the insured are measured by the non-forfeiture provisions—usually certain options for cash surrender value, paid-up insurance, or extended term insurance. * * *

"This case will illustrate the conclusion that may result that a policyholder still has a policy in force

> by reason of the waiver of premiums without any notice thereof to the insured."

In *Wick v. Western Mutual Life Insurance Company*, 175 Pac. 953 (Wash. 1918), the terms of the policy were substantially the same as those in the case at bar. The insured became disabled while the policy was in force, but made no claims for benefits until after the policy had lapsed for non-payment of premiums. The Supreme Court held that proof of disability should have been submitted to the company on or before the date when the payment fell due.

In *Jones v. New York Life Insurance Co.*, 290 Pac. 333 (Wash.), the insurance company had received letters in which it was informed that the insured was or had been ill. The company paid some of the benefits and then undertook to recover them. The Supreme Court of Washington in that case held that the insured was not entitled to total and permanent disability benefits for any period preceding the presentation of the proofs of the insured.

In *Brams v. New York Life Insurance Co.*, 299 Pa. 11, 148 Atl. 855, the policy contained a provision:

> "Upon receipt at the company's home office, before default in payment of premium, of due proof that the insured is totally disabled, as above defined, and will be continuously so totally disabled for life * * * the following benefits will be granted."

Before lapse in payment of premium the insured's sister wrote the company that the insured was sick and would pay his premium as soon as he recovered. No notice

of disability was furnished and the premium was never paid. The insured died and a claim was made on his policy. The Pennsylvania Supreme Court held that the letter written by the insured's sister was not a compliance with the provisions of the contract, and that the insured and his beneficiary were bound to have made the proof prior to default.

In *Hanson v. Insurance Co.*, 229 Ill. App. 15, it was held (quoting from the syllabus):

> "Where a life policy provides for the waiver of premiums during * * * until disability * * * upon the furnishing * * * of proof * * * of such disability and the endorsement thereby by the insurer on the agreement and * * * the insured was disabled five days before his premium was due and died after the due date without payment thereof or without making any proof of disability, there could be no recovery on the policy."

As against these well-reasoned and firmly established authorities, we find several cases cited by appellant, practically all of which are from Kentucky and Texas (two jurisdictions noted for their ultra liberal doctrines). The *Marshall* case and other cases cited by appellant are easily distinguished from the instant case on at least two different grounds: The first is stated in the *Marshall* case at page 979 (App. Op. Br. p. 45):

> "*A construction making the disability benefits to begin as of the time of proof might be all right where such benefits are sought while the insured is living, but a disability provision such as the one to be construed where the disability occurs near the due date of the premium and continues until death, is made*

> *worthless by holding that the proof of disability and not the disability itself, makes it operative.*" (Italics ours.)

and, second, in all of appellant's cases proof of disability within a reasonable time is required.

In the case before Your Honors the insured is still alive. Proof of disability was submitted over three years after the alleged disability commenced and two years after applications were made for disability benefits from the Acacia and Metropolitan insurance companies. At the outset it might be well to note that practically all of the cases cited by appellant, like the *Marshall* case, involved the death of the insured and submission of proofs of disability within a very short time thereafter.

The case of *Minnesota Mutual Life Insurance Co. v. Marshall*, 29 Fed. (2d) 977 (App. Op. Br. 41), is easily distinguished from the case at bar on its facts. The premium fell due on October 14, 1926. There was a grace period of thirty days, which continued the policy in force to and including November 14, 1926. Plaintiff was operated on for appendicitis November 16, 1926, and died November 29th. The jury found he had become totally and permanently disabled prior to November 14, 1926. Between the dates when the policy was in force, November 14th, and November 29th, the date of his death, a period of fifteen days elapsed, while in the case at bar, aopting plaintiff's own theory, a period of three years elapsed. We do not believe the above court, or any court, would or could have made the same ruling had three years elapsed instead of fifteen days. In regard to this situation the court stated (978):

> "On the question of when the time of waiver of the payment of premiums begins under the policy provisions similar to those quoted, *there are two lines of decisions, one holding that proof of disability fixes the time when the waiver begins, and the other holding that the time of waiver is the time of disability and that a reasonable time thereafter is allowed to make proof of such disability*, and that if death occurs before the proof of disability is made, although after the due date of the premium, the insurance company is liable where the disability arises before the due date of the premium and continues until death." (Italics ours.)

and also the statement quoted *supra*.

Southern Life Insurance Co. v. Hazard, 148 Ky. 465, 146 S. W. 1107 (App. Op. Br. 46), is also cited. In this case also the insured died and proofs were furnished within a reasonable time, *i. e.*, within seven weeks.

Merchants Life Insurance Co. v. Clark (Tex. Civ. App.), 256 S. W. 969 (App. Op. Br. 48), is also cited. The facts in this case show that there was a failure to present proof within thirty-five days, as distinguished from the case before Your Honors, where the failure to present proof continued for three years. And, again, in this case the insured died.

The next case cited is *Missouri State Life Insurance Co. v. LeFevere* (Tex. Civ. App.), 10 S. W. (2d) 267 (App. Op. Br. 49). Here the assured's premium was due April 8, 1927. He became disabled February 20, 1927, and died June 6th of that year. The lapse of time from the date of default to the date of death was fifty-eight days. The court stated in its opinion (269):

> "We also think under the circumstances of this case that a duty rested upon anyone to make the proof within a reasonable time after the same could be made, and that the offer of appellee to make such proof on June 17, 1927, after the death of the assured on June 6, 1927, was within a reasonable time after the same could be made."

In this case, in spite of so short a time, namely, fifty-eight days, we note that the court apparently justified its decision on the fact that the assured was under both a mental disability and a physical disability, which made him unable to give a notice of disability or present a claim. In the case before Your Honors there was no such disability existing. While it may be true that the pneumonia and pleurisy kept Mr. McCulloch in his bed for some time, the evidence is clear that he was up and about the hospital when he returned to it until the time he went out of business. The evidence was clear that he found time enough to file a claim with two other insurance companies stating that his disability commenced as of a date different than the date presented in this case; and, further, he then, after submitting proofs to those companies, waited two years and more before making any claim upon the defendant here.

The next case cited is *Metropolitan Life Insurance Co. v. Carroll* (Ky.), 273 S. W. 54 (App. Op. Br. 51). Here the assured's premium became due June 27, 1923, with a grace period of thirty-one days. The assured became totally and permanently disabled July 19th and died July 30th of that year. Here again is a trivial lapse of time of a mere seventeen days and the court, in its

decision, relies upon the physical disability of the assured to present a claim or make proof. Note that this is also a death case.

On page 52 of appellant's opening brief we find the case of *Fidelity Mutual Life Insurance Co. v. Gardner's Administrators*, 233 Ky. 88, 25 S. W. (2d) 69. In this case permanent and total disability occurred within the grace period after the unpaid premium fell due. Notice of death, etc., was given two weeks after the grace period expired. The court stated:

> "Three days after the death his administrator offered to prove his prior disability and death. Clearly this was within a reasonable time."

The lapse of time here was trivial and the court emphasized the fact that the disability occurred within the grace period and that proof thereof was made within a reasonable time. This case, too, was a death case.

The next case cited is *Bank of Commerce & Trust Co. v. Northwestern National Life Insurance Co.* (Tenn.), 26 S. W. (2d) 135 (App. Op. Br. 53). In this case there was but a lapse of nine days prior to the filing of the claim, and this case also involved the death of the assured.

The next case is *Mid-Continent Life Insurance Co. v. Hubbard* (Tex.), 32 S. W. (2d) 701 (App. Op. Br. 53). Here there was a lapse of approximately fourteen days and the court discussed the insured's physical disability to present his claim. This, too, was a death case.

The next case is *Inter-Southern Life Insurance Co. v. Hughes' Committee*, 224 Ky. 405, 6 S. W. (2d) 447

(App. Op. Br. 55). This case is out of point. It involved a question of insanity and the fraudulent act of an insurance company in taking up an insurance policy of an insane insured.

The next case is *Levan v. Metropolitan Life Insurance Co.,* 138 S. C. 253, 136 S. E. 304 (App. Op. Br. 56). Here the premium fell due June 5, 1923. The grace period of the policy extended it to July 5th of that year. The insured was insane when the premium fell due in June and was sent to an insane hospital late in the year. He died January 12, 1924. The claim was made within six months after the insured was permanently and totally disabled, and more noteworthy is the fact that the court found that by reason of his condition, the insured was not able to give notice to the company. In spite of the majority opinion, there is a well-considered dissenting opinion quoting numerous authorities to the contrary. We submit that the facts in this case are much different from those in the case at bar, especially in that the time within which the notice was given was at least reasonable, and here, too, was a death case.

Appellant cited *McColgan v. New York Life Insurance Co.,* 36 Ohio. App. 123, 172 N. E. 849 (App. Op. Br. 56). Here notice of disability and death was given to the company within six months after the default, and this also was a death case.

The next case cited is *State Life Insurance Co. v. Fann* (Tex.), 269 S. W. 111 (App. Op. Br. 57). The insured became disabled April 1, 1922, by reason of insanity. The premium note he had given fell due June 20th of that year. He died November 6, 1923. The insured,

being insane, was under a mental disability which prevented his making proof. This was a death case, and the lapse of time was much less than that in the case before Your Honors. There is no claim that Mr. McCulloch was physically unable to sign or present the proof of disability at least as early as the time when he performed similar acts in respect to the Metropolitan and Acacia policies, at which time he knew of his condition.

Appellant also cites *Hageman v. Equitable Life Assurance Society* (Ky.), 282 S. W. 112 (App. Op. Br. 59). Here the assured became permanently and totally disabled June 5, 1923. The premium fell due September 1st of that year. He gave a report on July 15, 1923, of his illness, but defined it as partial disability. The court held, however, that the information was in the hands of the company as to disability, and even though the assured had classed it as partial, it was, as a matter of law, total. We do not consider the case applicable to the facts in the case at bar.

Aetna Life Insurance Co. v. Palmer, 159 Ga. 321, 125 S. E. 829 (App. Op. Br. 60), is cited. This case, however, is not in point and does not involve the question of giving any notice. The question involved was whether or not plaintiff could recover if he became totally and permanently disabled during the grace period of the policy.

Hawthorne v. Travelers Protective Assn., 112 Kan. 356, 210 Pac. 1086 (App. Op. Br. 61), does not involve any of the questions involved in the instant case. It concerns a health and accident policy. There was no

default in the payment of any premium and there was no question of waiver of premium involved.

The other cases cited by appellant are not even claimed to be applicable.

We submit that even a cursory examination of the cases just discussed shows that they are all cases involving the death of the insured and cases where the insured, by reason of his disability or death, was prevented from making proof of claim, and most striking of all is the language of the court in most of them that proof was made within a *reasonable time*. In discussing these cases we have not attempted to go into the language of the policy in each, but have discussed the cases upon the merits as brought forth by the facts involved. The provisions in many of the policies involved in those cases were entirely different from those before Your Honors, and we submit that in this case proof of disability should have been furnished while the policies were in force.

IV.

Plaintiff's Cause of Action Is Barred by Plaintiff's Laches.

Independent of other reasons why plaintiff cannot recover in this case, we find that defendant was greatly prejudiced by the laches of plaintiff in the presentation of his claim. Laches, to bar relief, imputes some degree of fault. It is certain that at least as far back as August, 1927, when plaintiff made proof to Metropolitan and Acacia, he knew his condition. We contend that, even if it could be construed that the lapsed and surrendered policies could have been construed to be in force at that

time, both in law and in fact he knew their provisions. The law is clear that parties are held to a reasonable degree of diligence in learning of, as well as enforcing, their rights, and negligence is no excuse for ignorance.

Tarke v. Bingham, 123 Cal. 163.

In *Ater v. Smith*, 243 Ill. 57, 91 N. E. 776, the court stated:

> "Persons cannot close their minds to every avenue of information and knowledge, benumb acquisitive instinct with indifference and subsequently expect courts to relieve them from their self-imposed ignorance."

In *Broaddus v. Broaddus*, 144 Va. 727, 130 S. E. 794, it was stated:

> "The test is not what the plaintiff knows, but what he might have known by the use of the means of information within his reach with the vigilance the law requires of him."

In *Scranton Gas & Water Co. v. Lackawanna, etc., Co.*, 167 Pa. 136, 31 Atl. 484, it was stated:

> "Three years now is longer in events and progress than twenty years some centuries ago, when the statutes of limitation were adopted in England."

Note:

> *Williams v. Woodruff*, 36 Colo. 28, 85 Pac. 90, holding that the disadvantage resulting from delay may come from a variety of causes, including the death of parties or witnesses.

See, also:

> *Hammond v. Hopkins*, 143 U. S. 224;
> *Kleinclaus v. Dutard*, 147 Cal. 245.

Plaintiff will undoubtedly argue that the defendant has had the use of the money which it would have been paying plaintiff if plaintiff had acted promptly. However, we submit that if plaintiff had acted promptly, the defendant could have made an investigation of the facts and further physical examinations could have been made of the plaintiff to determine what his true condition was. Further examination might have disclosed what Dr. Anderton found when he examined Mr. McCulloch in February, 1927, and a score or more doctors who could have made such investigation and examination might well have been before the trial court to testify as to what they found. At least they could have learned the true facts. The record in this case also discloses that Don Carrell, the one material witness for the defendant upon the matter of the notes and checks, was actually upon his deathbed when the case was tried [Tr. 228].

The plaintiff, by his delay in bringing this suit, has made it practically impossible for the defendant to prepare a complete and unambiguous defense. Equity regards stale claims with disfavor and long lapse of time unexplained. Even one year, of itself not a bar to relief under the statute of limitations, operates by way of evidence against the justice of the right asserted. It not only subjects plaintiff's case to more severe criticism and scrutiny than it would otherwise receive, and exacts of him a higher degree of proof than would otherwise be required, but moves the court to look with more indulgence on the evidence adduced by the defendant. This

is the rule in both the federal courts and in the California courts.

Pond Creek Coal Co. v. Hatfield, 239 Fed. 622;
Updike v. Mace, 194 Fed. 1001;
Elliott v. Bunce, 10 Cal. App. 741.

Regardless of the other defenses established by the defendant, we submit that the laches of plaintiff alone should bar his recovery.

Conclusion.

A review of the facts of this case and the law applicable thereto discloses that the conditions in the policies involved make submission of proofs of total disability before a default in payment of premium a condition precedent to recovery. A review of the precedents discloses that the more enlightened courts everywhere hold that unless such proofs are submitted while the policy is in force, the insured or his estate or beneficiary cannot recover. The few remaining decisions are uniform in holding that proof of disability must be submitted within a reasonable time, and no case has been cited where the lapse of time after the alleged disability consisted of more than six months. The record in this case clearly shows that defendant was greatly prejudiced by the delay of the plaintiff in presenting his claim.

We therefore respectfully submit that the judgment of the trial court should be affirmed.

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